BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
PAUL K. BARKAL, M.D. Certificate #A-44292	)	No: 10-91-15215
Respondent.	)	

DECISION AND ORDER

The attached Stipulation in Settlement and Decision is hereby adopted by the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in the above-entitled matter.

This Decision shall become effective on August 8, 1997.

DATED July 9, 1997.

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ira Lubell, M.D.
Chair, Panel A

DANIEL E. LUNGREN, Attorney General
of the State of California
STEVEN H. ZEIGEN,
Deputy Attorney General, State Bar No. 60225
Department of Justice
110 West A Street, Suite 1100
Post Office Box 85266
San Diego, California 92186-5266
Telephone: (619) 645-2074

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Paul Kevin Barkal, M.D. 4501 Mission Bay Dr. San Diego, CA 92109 Physician's and Surgeon's Certificate No. A044292 Respondent.	Case No. 10-91-15215 STIPULATION IN SETTLEMENT AND DECISION

Complainant, Ron Joseph, Executive Director of the Medical Board of California, by and through his attorney, Daniel E. Lungren, Attorney General of the State of California, by Steven H. Zeigen, Deputy Attorney General, and Paul Kevin Barkal, M.D. ("respondent"), by and through his attorney David Rosenberg, Esq., hereby stipulate as follows:

1. The Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs ("Division") acquired jurisdiction over respondent by reason of the following:

A. Respondent was duly served with a copy of the Accusation, Statement to Respondent, Request for Discovery,

Form Notice of Defense and copies of Government Code sections 11507.5, 11507.6 and 11507.7 as required by section 11503 and 11505, and respondent filed a Notice of Defense within the time allowed by section 11506 of the code.

B. Respondent has received and read the Accusation, the First Supplemental Accusation, and the Second Supplemental Accusation which are presently on file as Case No. 10-91-15215, before the Division. Respondent understands the nature of the charges alleged in the Accusation and that the charges and allegations constitute cause for imposing discipline upon respondent's license to practice medicine which was issued by the Medical Board of California ("Board").

2. Respondent and his counsel are aware of each of respondent's rights, including the right to a hearing on the charges and allegations, the right to confront and cross-examine witnesses who would testify against respondent, the right to present evidence in his favor and call witnesses on his behalf, or to testify, his right to contest the charges and allegations, and other rights which are accorded to respondent pursuant to the California Administrative Procedure Act (Gov. Code, § 11500 et seq.), including the right to seek reconsideration, review by the Superior Court, and Appellate Review.

3. Respondent freely and voluntarily waives each and every one of the rights set forth in paragraph 2.

4. Respondent understands that in signing this stipulation rather than contesting the Accusation, he is enabling the Division to issue the following order without further

process.

5. For the purpose of resolving Accusation No. 10-91-15215, respondent admits that during the period January 1, 1992 through February 20, 1992, he was negligent in his treatment of three patients as alleged in the underlying original Accusation paragraphs 12 through 13; 15 through 16; 17 through 18. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

Pursuant to this stipulation, the charges and allegations contained in the First and Second Supplemental Accusations are hereby dismissed. No further charges be filed against respondent on facts that are currently available to complainant Board.

6. The admissions made by respondent herein are for purposes of this proceeding, for any other disciplinary proceedings by the Division, and for any petition for reinstatement, reduction of penalty, or application for relicensure, and shall have no force or effect in any other case or proceeding.

7. It is understood by respondent that, in deciding whether to adopt this stipulation, the Division may receive oral and written communications from its staff and the Attorney General's office. Communications pursuant to this paragraph shall not disqualify the Division or other persons from future participation in this or any other matter affecting respondent. In the event this settlement is not adopted by the Division, the stipulation will not become effective and may not be used for any purpose, except for this paragraph, which shall remain in effect.

8. Based upon the foregoing, it is stipulated and agreed that the Division may issue the following as its decision in this case.

ORDER

IT IS HEREBY ORDERED that Respondent Paul Kevin Barkal, M.D. is placed on probation for five (5) years on the terms and conditions set forth below. Within 15 days after the effective date of this decision, respondent shall provide the Division, or its designee, proof of service that respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent or where respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to respondent.

1. **DRUGS AND ABSTAIN FROM USE**

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, and dangerous drugs as defined by Section 4211 of the Business and Professions Code, or any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner.

2. **BIOLOGICAL FLUID TESTING**

Respondent shall immediately submit to biological fluid testing, at respondent's cost, upon the request of the Division or its designee.

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3. **EDUCATION COURSE**

Within 90 days from the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval an educational program or course to be designated by the Division, which shall not be less than 40 hours per year, for each year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of continuing medical education of which 40 hours were in satisfaction of this condition and were approved in advance by the Division or its designee.

4. **ETHICS COURSE**

Within 60 days of the effective date of this decision, respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

5. **PSYCHIATRIC EVALUATION**

Within 30 days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Division or its designees, respondent shall undergo a psychiatric evaluation and psychological testing by a Division approved psychiatrist or psychologist, who shall furnish an evaluation report to the Division or its designees. The respondent shall pay the cost of the psychiatric evaluation.

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6. **PSYCHOTHERAPY**

Within 60 days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval the name and qualifications of a licensed psychologist or licensed psychiatrist of respondent's choice. Upon approval, respondent shall undergo twice weekly psychotherapy sessions for the first six months, and then weekly psychotherapy sessions for a minimum of another eighteen months, and shall continue such treatment beyond that time until the Division or its designee deems, based upon reports filed by the designated psychotherapist, that no further psychotherapy is necessary. Respondent shall have the treating psychotherapist submit quarterly reports status reports to the Division or its designee.

7. **MONITORING**

Within 30 days of the effective date of this decision, respondent shall submit to the Division or its designee for its prior approval a plan of practice in which respondent's practice shall be monitored by another physician in respondent's field of practice, pain management, who shall provide periodic reports to the Division or its designee.

If the monitor resigns or is no longer available, respondent shall, within 15 days, move to have a new monitor appointed, through nomination by respondent and approval by the Division or its designee.

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8. **GEOGRAPHICAL LIMITATION**

Respondent shall maintain no medical office more than a one hour drive from the location of his main medical office.

9. **OBEY ALL LAWS**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

10. **QUARTERLY REPORTS**

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

11. **PROBATION SURVEILLANCE PROGRAM COMPLIANCE**

Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his or her addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 days.

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12. **INTERVIEW WITH THE DIVISION, ITS DESIGNEE OR ITS DESIGNATED PHYSICIAN(S)**

Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

13. **TOLLING FOR OUT-OF-STATE PRACTICE, RESIDENCE OR IN-STATE NON-PRACTICE**

In the event respondent should leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding 30 days in which respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

14. **COMPLETION OF PROBATION**

Upon successful completion of probation, respondent's certificate shall be fully restored.

15. **VIOLATION OF PROBATION**

If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may impose an order of suspension or revocation as

warranted by respondent's conduct, as if a suspension or revocation had originally been imposed and stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. **COST RECOVERY**

The respondent is hereby ordered to reimburse the Division the amount of $7,500.00 for its investigation and prosecution costs. Respondent shall pay the entire amount within two years from the effective date of this decision, in amounts to be agreed upon between respondent and the division. Failure to reimburse the Division's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Division agrees in writing to another payment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

17. **PROBATION MONITORING COSTS**

Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Division at the beginning of each calendar year. Failure to pay such costs shall constitute a violation of probation.

18. **LICENSE SURRENDER**

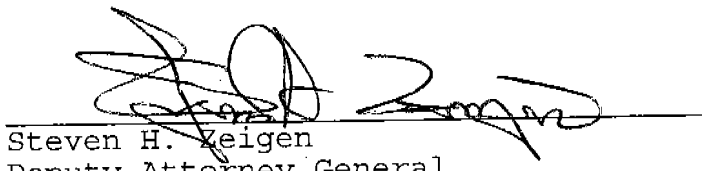
Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons or

is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his certificate to the Division. The Division reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to terms and conditions of probation.

We concur in the stipulation and order.

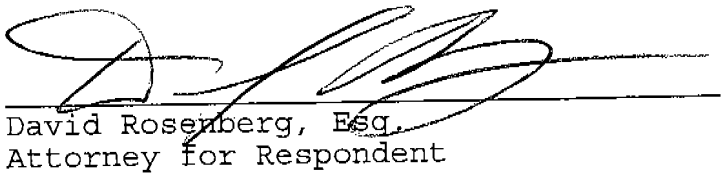
DATED: 5/28/97

DANIEL E. LUNGREN, Attorney General
of the State of California



Steven H. Zeigen
Deputy Attorney General
Attorneys for Complainant

DATED: 5/14/97



David Rosenberg, Esq.
Attorney for Respondent

I have carefully read and fully understand the stipulation and order set forth above. I have discussed the terms and conditions set forth in the stipulation and order with my attorney, David Rosenberg, Esq. I understand that in signing this stipulation I am waiving my right to a hearing on the charges set forth in the Accusation on file in this matter. I

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further understand that in signing this stipulation the Division may enter the foregoing order placing certain requirements, restrictions and limitations on my right to practice medicine in the State of California.

DATED: 4/30/97

Paul Kevin Barkal, M.D.
Respondent

DANIEL E. LUNGREN, Attorney General
of the State of California
SHERRY L. LEDAKIS, [State Bar No. 131767]
Deputy Attorney General
STEVEN H. ZEIGEN, [State Bar No. 60225]
Deputy Attorney General
Department of Justice
110 West A Street, Suite 1100
Post Office Box 85266
San Diego, California 92186-5266
Telephone: (619) 645-2074

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PAUL KEVIN BARKAL, M.D. 145 Rivershire Lane Lincoln Shire, IL 60069 ~~4540 Park Newport~~ Newport Beach, CA 92660 Physician's and Surgeon's License No. A044292 Respondent.	NO. 10-91-15215 ACCUSATION

Complainant Dixon Arnett, who as causes for disciplinary action, alleges:

PARTIES

1. Complainant is the Executive Director of the Medical Board of California ("Board") and makes and files this Accusation solely in his official capacity.

LICENSE STATUS

2. On or about December 14, 1987, Physician's and

Surgeon's License No. A044292 was issued by the Board to Paul Kevin Barkal, M.D. ("respondent"), and at all times relevant herein, said Physician's and Surgeon's License was, and currently is, in full force and effect.

JURISDICTION

3. This Accusation is made in reference to the following statutes of the California Business and Professions Code ("Code"):

A. Section 2227 provides that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 provides that the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct.

C. Unprofessional conduct is that conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.

D. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

"(c) Repeated negligent acts.

"(e) The commission of any act involving dishonesty or corruption which is

substantially related to the qualifications, functions, or duties of a physician and surgeon."

E. Section 2261 provides that knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct.

COSTS

4. Section 125.3 provides, in pertinent part, that in any order issued in resolution of a disciplinary proceeding before any board within the department, the board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

CHARGES AND ALLEGATIONS

5. Background Information

A. In approximately March of 1991, respondent, an anesthesiologist, set up a medical practice in pain management in San Diego, California. He accepted chronic pain patients who required a hospital setting for some of their treatments, even though he lacked hospital

privileges and was unable to obtain any in San Diego.

B. Respondent applied for privileges at the San Diego Rehabilitation Institute on November 10, 1990. On April 4, 1991, the Executive Committee of the Medical Staff of San Diego Rehabilitation Institute recommended to the Governing Board that respondent's application for membership be denied. The reasons stated for the denial included respondent's unexplained leave of absence from medical school, his dismissal from an internship for what was described as "serious problems." They were unable to substantiate his completion of an internship. Northwestern University Medical School indicated that respondent was terminated from their residency program after nine months because of "substandard performance." A letter from the University of California at Los Angeles indicated that respondent had "a disturbing tendency to manipulate trainee peers to his own advantage." His curriculum vitae states that he was employed by a company from December of 1985 to July of 1986, however, the company denies any record of previous employment. Furthermore, respondent's application stated that he currently had hospital privileges at two hospitals. One of the hospitals only corroborated "several temporary privileges," but that he was not currently a staff member. The other hospital stated that respondent had been "affiliated" with them in August of 1988, and July of 1989, as "back up coverage." They failed to mention

current privileges.

C. The Rehabilitation Institute also sent respondent a complaint it had received from a woman which respondent had attempted to treat and then whom he abandoned.

6. Respondent has subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of general unprofessional conduct. Said unprofessional conduct included, but was not limited to, the following:

A. Paragraph 5, above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent accepted chronic pain patients who required hospital settings for some treatments even though he lacked hospital privileges; and

C. Respondent made misrepresentations on his application for privileges at the San Diego Rehabilitation Institute.

7. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of unprofessional conduct, as defined by section 2261 of the Code, in that he knowingly made or signed a document directly or indirectly related to the practice of medicine which falsely represents the existence or non-existence of a state of facts, in the practice of his profession, as more particularly alleged hereinafter:

A. Paragraph 5, above is incorporated by

reference and realleged as if fully set forth herein.

B. Respondent is guilty of knowingly and falsely signing a document related to the practice of medicine. Said making or signing included, but was not limited to, the following:

> Respondent made misrepresentations on his application for privileges at the San Diego Rehabilitation Institute, and on his curriculum vitae.

8. Patient Karen S.:

A. On February 18, 1991, patient Karen S., a chronic pain patient with a morphine pump, contacted respondent to refill the pump during the first week of March 1991. Respondent assured her that he would refill the pump. He told her that he was in the process of setting up a pain management center and if it was not up and running by March 1991, he would meet her at an Emergency Room and refill the pump. At respondent's request, Karen S. had all of her medical records sent to him.

B. On Sunday, March 3, 1991, the alarm in the pump started beeping indicating that the medication level was low and that the pump needed to be refilled within four days. Karen S. called respondent on Monday, March 4, 1991, and he reassured her he would take care of her and not to worry. When she called him back later on in the day, he failed to return her phone call. She called him on Tuesday morning, March 5,

1991, and again at noon on Tuesday, without a return phone call.

C. Karen S. called her daughter-in-law, and asked her to call respondent. Respondent called Karen S.'s daughter-in-law and told her that he was making the final arrangements for the pump refill, and that he would be calling Karen S. later in the day with the arrangements. He failed to do this.

D. On Wednesday, March 6, 1991, at 10:30 a.m., Karen S. went to respondent's office and asked the receptionist to page him. Respondent spoke to Karen S. over the telephone and told her that he had made arrangements with a nurse (L.C.) at U.C.S.D. to refill the pump either that afternoon or Thursday morning. Respondent stated that this would be a "one-time shot" and that Karen S. would remain his patient. Respondent promised to call her later that day. At 4:30 p.m. when respondent failed to call Karen S. with the arrangements, she paged him. But respondent did not call her back. She then called L.C. at U.C.S.D. but she had left for the day, however, L.C. did call her back that evening.

E. L.C. told Karen S. that she had not agreed to refill her pump, and she had not talked to respondent until 3:00 p.m. that day. L.C. stated that she told respondent that Karen S. would need to be seen by a physician at U.C.S.D. and the morphine pump ordered by that physician. L.C. told respondent to

contact a physician at U.C.S.D. to see Karen S. Respondent failed to do this.

F. Karen S. called respondent three times on Thursday, March 7, 1991, without respondent returning her phone calls. She called the manufacturer of the pump to obtain the names of physicians' who could refill the pump, however, she was unable to obtain an immediate appointment. Therefore, on Friday, March 8, 1991, her son drove her to Oxnard, California, 225 miles from her home, in order to obtain a pump refill. She was in extreme pain during the commute, and she was bedridden for four days following the trip to Oxnard. Respondent abandoned his patient Karen S.

G. Patient Karen S. requested her medical records back from respondent, however, he refused to return them.

9. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of general unprofessional conduct. Said unprofessional conduct included, but was not limited to, the following:

A. Paragraph 8, above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent repeatedly told patient Karen S. that he would get her pump refilled when he could not do so. Furthermore, respondent failed to refer her to someone else who could and would timely refill her pump.

10. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of unprofessional conduct, as defined by section 2234(c) of the Code, in that he is guilty of repeated negligent acts in the practice of his profession as more particularly alleged hereinafter:

A. Paragraph 8, above is incorporated by reference and realleged as if fully set forth herein.

B. Respondent is guilty of repeated negligent acts in his care and treatment of patient Karen S. Said negligent acts include, but are not limited to, the following:

(1) Respondent failed to find someone for Karen S. who would timely refill her morphine pump; and

(2) Respondent failed to return Karen S.'s medical records when she requested them.

11. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234(e) in that he committed acts of dishonesty and corruption, in the practice of his profession. Said dishonesty and corruption included, but was not limited to, the following:

A. Paragraph 8, above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent falsely told patient Karen S. that

he would refill her morphine pump; and

C. Respondent failed to obtain another physician to refill the patient's pump.

12. Patient Glen P.:

A. On June 25, 1991, patient Glen P. went to see respondent for Glen P.'s extreme lower back pain. Respondent's treatment included analgesic injections into the affected facet joints. After two such injections, respondent planned to do a permanent facet deneration with cryoanalgesia which was originally scheduled for August 7, 1991. Respondent told Glen P. that the entire three part procedure would cost no more than $1,500-$2,000.

B. Glen P. underwent the first two injections, and then for the next two months, respondent's office scheduled, cancelled, rescheduled and cancelled the third aspect of the procedure several times. This procedure was finally scheduled for November 13, 1991, at a radiology clinic. On November 13, 1991, Glen P. learned on his own that the procedure had again been cancelled because respondent did not have a valid radiological certificate (necessary to perform the procedure) and that respondent lacked hospital privileges at El Cajon Valley Hospital, Mercy, Sharp, Alvarado or any other hospital.

C. Glen P. called respondent's office many times after November 13, 1991, leaving messages, however, respondent never returned Glen P.'s phone

calls. Glen P. did, however, receive a bill from respondent's office for $1,961.80, even though the last procedure had never been performed. The patient was unable to locate respondent or his medical records and respondent's employees had closed the office. Respondent abandoned patient Glen P.

13. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of general unprofessional conduct. Said unprofessional conduct included, but was not limited to, the following:

A. Paragraph 12, is incorporated by reference and realleged as if fully set forth herein. Said unprofessional conduct included, but was not limited to, the following:

B. Respondent scheduled patient Glen P. for a hospital procedure when respondent lacked privileges at that hospital;

C. Respondent failed to obtain another physician to perform the procedure for patient Glen P.;

D. Respondent failed to inform Glen P. that the procedure had been cancelled because respondent lacked hospital privileges;

E. Respondent failed to return Glen P.'s phone calls and medical records; and

F. Respondent abandoned his patient Glen P.

14. Respondent has further subjected his license to disciplinary action under California Business and Professions

Code sections 2220, 2227 and 2234(e) of the Code, in that he has committed acts of dishonesty or corruption in the practice of his profession. Said dishonest or corrupt acts included, but were not limited to, the following:

A. Paragraph 12, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent billed his patient Glen P. for procedures that were not performed.

15. Patient Edward S.:

A. On or about August 7, 1991, respondent saw patient Edward S. who had a history of chronic low back pain from an industrial accident. Respondent scheduled Edward S. for implanted "spinal stimulation" surgery at Sharp Hospital. The patient discovered by himself, the day before the scheduled surgery by calling the hospital, that respondent had cancelled the surgery for lack of hospital privileges.

B. Respondent then attempted to schedule the same surgery for Edward S. at Grossmont Hospital with the same chain of events occurring as had occurred at Sharp Hospital, including the fact that the patient learned on his own that respondent had cancelled the surgery. Subsequently, respondent left the area and Edward S. was unable to locate him. Edward S. attempted to locate respondent through a psychologist, W. McK, Ph.D., who had been working with respondent's patients. Dr. McK did not know of respondent's whereabouts and referred Edward S. to another

physician. Edward S. was unable to obtain his medical records from respondent until June of 1993, and at that time they were incomplete. Respondent abandoned his patient Edward S.

16. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of general unprofessional conduct. Said unprofessional conduct included, but was not limited to, the following:

A. Paragraph 15, is incorporated by reference and realleged as if fully set forth herein.

(1) Respondent scheduled patient Edward S. for a hospital procedure when respondent lacked privileges at that hospital;

(2) Respondent failed to obtain another physician to perform the procedure for Edward S.;

(3) Respondent failed to inform Edward S. that the procedure had been cancelled because respondent lacked hospital privileges;

(4) Respondent failed to return Edward S.'s phone calls and medical records; and

(5) Respondent abandoned his patient Edward S.

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17. Patient Dorothy R.:

A. On November 13, 1991, patient Dorothy R. saw respondent for pain management of her lower back. A treatment plan was devised wherein Dorothy R. was told by respondent that she would be pain free in 90 days. She received facet joint injections by respondent on December 18, 1991. It was her understanding that respondent would continue her treatment after this date, however, respondent left his practice without any explanation to Dorothy R. She was unable to locate respondent or obtain her medical records from respondent's office. Finally on February 20, 1992, she received a form letter from respondent stating that he had left the state because of his father's stroke. He referred her back to the physician who had referred her to him.

18. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of unprofessional conduct, as defined by section 2234(c) of the Code, in that he is guilty of repeated negligent acts in the practice of his profession as more particularly alleged hereinafter:

A. Paragraph 17, above is incorporated by reference and realleged as if fully set forth herein.

B. Respondent is guilty of repeated negligent acts in his care and treatment of patient Dorothy R. Said negligent acts include, but are not limited to,

the following:

(1) Respondent failed to follow-up with his patient's treatment and failed to refer her to anyone else;

(2) Respondent failed to appropriately document his treatment plan for Dorothy R.'s back pain;

(3) Respondent failed to return patient Dorothy R.'s medical records when she requested them; and

(4) Respondent abandoned his patient Dorothy R.

19. Abandonment of practice.

A. In October or November of 1991, respondent abruptly left the state of California to attend to his ill father without informing his patients, staff or colleagues of his whereabouts. He remained gone for approximately one month. Soon after his return to San Diego, he departed again without making any coverage arrangements for his patients.

B. In February of 1992, respondent finally wrote his patients informing them that he would be leaving the state and to obtain another referral for pain management from their referring physicians.

C. When respondent left his San Diego practice, he left without paying several of his employees who eventually filed Labor Board actions against him. He also failed to pay rent owed to the physician whose office he worked out of. This

physician filed a complaint with the Medical Board expressing concerns about respondent's mental stability.

20. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 of the Code, on the grounds of general unprofessional conduct. Said unprofessional conduct included, but was not limited to, the following:

A. Paragraph 19, above, is incorporated by reference and realleged as if fully set forth herein.

(1) Respondent left the state without informing his patients and without referring them to other physicians who could continue their care;

(2) Respondent abruptly left the state without informing his staff that he was going, and without paying them their salaries;

(3) Respondent abruptly left the state without informing his colleagues, nor his associates; and

(4) Respondent abruptly left the state without paying office rent owed to another physician.

21. Stalking of Karen A.:

A. In or about July of 1991, Karen A., began working for respondent as his office manager. During that period of time she observed him cancelling patient

appointments without good cause, and heard him tell patients that he could perform procedures that required a hospital setting when she knew he had no hospital privileges. She also became personally involved with respondent.

B. In November of 1991, Karen A. quit working for respondent in order to break off their personal relationship. On November 24, 1991, Karen A. called her home telephone to get her messages and respondent picked up the telephone. Respondent did not live with Karen A. and did not have permission to be in her home. Respondent had removed a window screen and climbed into her apartment.

C. When respondent answered Karen A.'s telephone, Karen A. called the police. When they arrived at her apartment, respondent was inside. Karen A. told the officers that she had dated respondent for approximately five months and that she had tried to break up with him a few weeks earlier. He refused to accept the break-up and continued to call her and come by her apartment. Karen A. did not file charges against respondent.

D. On December 12, 1991, respondent went to Karen A.'s apartment, pushed her aside and forcefully pushed his way into her apartment. A friend of Karen A.'s, S.B., was inside of the apartment. Respondent and S.B. began to struggle and respondent bit S.B. on the arm. Karen A. called the police, respondent left

and photographs were taken by the police of the bite marks. The victims did not press charges.

E. Between December of 1991, and February of 1992, respondent waited outside of Karen A.'s apartment on numerous occasions for several hours at a time. She moved to an upstairs apartment to feel safer. Respondent threw rocks at her window. He left several gifts, including jewelry and body lotions at her apartment.

F. On or about April of 1992, Karen A. wrote respondent a letter telling him to leave her alone and that she wanted nothing more to do with him. During this month, he left a book on her car.

G. Karen A. again called the police when respondent arrived at her home. Before they arrived, respondent appeared to be attempting to look into Karen A.'s apartment from across the street, with binoculars.

H. On April 20, 1992, Karen A. obtained a temporary restraining order (TRO) against respondent. He was served with the TRO by security guards at her place of employment when he arrived there that same day asking to see her. The security officers escorted him from the premises.

I. A permanent restraining order was issued on May 6, 1992. Karen A. continued to receive flowers, gifts and lengthy letters from respondent professing his love for Karen A. In August of 1992, respondent left a note on Karen A.'s car at her work place asking

that she meet him the next morning. Karen A. arrived at the appointed place with a friend who served respondent with the permanent restraining order enjoining respondent from contacting Karen A.

J. In spite of the restraining order, respondent continued to send Karen A. letters, gifts, flowers, etc. throughout the remainder of 1992 and 1993. He also asked a San Diego police detective to have Karen A.'s phone lines tapped because he was sure she was calling him and hanging up. A detective from the San Diego Police Department contacted respondent informing him that he (respondent) was in violation of the TRO. Karen A. had her telephone number changed at least twice and she moved to a place unknown to respondent.

K. In 1993, Karen A. changed employment and respondent's sister attempted to find out where Karen A. was working from Karen A.'s friends.

L. In October of 1993, Karen A. called respondent's sister and told her to stop contacting people in an effort to locate Karen A. Respondent's sister told Karen A. that he was there (at the sister's house) and that if Karen A. told him herself that the relationship was over, respondent might listen. Therefore, Karen A. spoke to respondent over the telephone. Respondent told Karen A. that neither he nor his family or friends would bother her again.

M. Despite the October conversation, Karen

A. continued to receive letters and a book from respondent at her mother's address. In February of 1994, Karen A.'s fiancee left a message on respondent's answering machine telling him to leave Karen A. alone.

N. In May of 1994, Karen A. received an extensive letter and two tapes from respondent at her mother's home. One of the tapes was a recording of a session that respondent had with an astrologer discussing his undying love for Karen A. He stated that his relationship with Karen A. would never be over. The other tape was of respondent's talking of his endless love for Karen A.

O. In May of 1994, upon leaving work, Karen A. noticed a car following her. The car followed her again two days later. The driver was a lone female with dark glasses. The woman parked across the street from Karen A.'s new residence. When Karen A. approached the car intending to confront the driver, the car drove off. Karen A. got the license plate number and contacted the police. The car was determined to be a rental car leased to Dana Tillson, of Levenberg Investigations in San Francisco, California. The owner of the company, Charles Levenberg, told the police that respondent had hired his company to locate Karen A. and that respondent did not tell him (Levenberg) about the TRO. As a result of the investigation, respondent was provided with Karen A.'s home address, prior to Levenberg being aware of

the TRO.

P. On August 22, 1994, while Karen A. was driving northbound on the freeway towards her home, she noticed a red Chrysler LaBaron convertible, with the top down coming up alongside of her on her left. After a while, the car changed lanes and got in front of her and flashed its brake lights, causing her to slow down. It was daylight and Karen A. observed respondent driving the car. Respondent moved to the exit lane for her exit, however, Karen A. continued driving north past her exit. Respondent got back into the lanes of traffic and followed Karen A. Karen A. called 9-1-1 on her cellular telephone. Respondent followed Karen A. off the highway and stopped behind her at a traffic light. He held up a newspaper to hide his face. She turned right and he turned left toward her home. That was the last time she saw him. The police charged respondent with stalking, a violation of Penal Code section 646.9

Q. Respondent's attorney told the police detective following Karen A.'s case that respondent intended to move from Orange County to the San Diego North County area. This is near the victim's home.

R. A Board certified psychiatrist, after reviewing the investigation in this matter, has opined that respondent appears to be an impaired physician who is in need of psychiatric evaluation prior to continuing to practice medicine and surgery in the

State of California, and that his ability to practice medicine safely may be impaired due to a mental or physical illness.

22. Respondent has further subjected his license to disciplinary action under California Business and Professions Code sections 2220, 2227 and 2234 on the grounds of general unprofessional conduct. Said unprofessional conduct included, but was not limited to, the following:

A. Paragraph 21, above, is incorporated by reference and realleged as if fully set forth herein.

B. Respondent broke into Karen A.'s apartment;

C. Respondent got into an altercation with Karen A.'s guest and bite him;

D. Respondent violated a temporary restraining order and permanent injunction against him filed by Karen A.; and

E. Respondent is/has stalked Karen A. resulting in the filing of criminal charges against him.

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PRAYER

WHEREFORE, complainant requests that the Board hold a hearing on the matters alleged herein, and that following said hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's License Number A044292, heretofore issued to respondent Paul Kevin Barkal, M.D.;
2. Granting the board its costs in the investigation and prosecution of this case; and
3. Taking such other and further action as the Board deems appropriate to protect the public health, safety and welfare.

DATED: April 28, 1995

Dixon Arnett
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

03573160-SD94AD0454

DANIEL E. LUNGREN, Attorney General
of the State of California
STEVEN H. ZEIGEN,
Deputy Attorney General, State Bar No. 60225
Department of Justice
110 West A Street, Suite 1100
Post Office Box 85266
San Diego, California 92186-5266
Telephone: (619) 645-2074

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PAUL KEVIN BARKAL, M.D. 4540 Park Newport Newport Beach, CA 92660 Physician's and Surgeon's Certificate No. A044292	NO. 10-91-15215 FIRST SUPPLEMENTAL ACCUSATION

Complainant Dixon Arnett alleges as follows:

23. He is the Executive director of the Medical Board of California ("Board") and makes and files this First Supplemental Accusation in his official capacity.

24. Complainant refers to the allegations contained in paragraphs 1 through 22 of the Accusation No. 10-91-15215 filed on or about April 28, 1995, and incorporates the same herein by reference as if fully set forth.

25. This amended accusation is made in reference to the following sections of the California Business and Professions Code:

a. Section 2234 (e) provides that it is unprofessional conduct to commit any act of dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

c. Section 2261 provides that the knowing making or signing of any document related directly or indirectly to the practice of medicine which falsely represents the existence or nonexistence of a state of facts constitutes unprofessional conduct.

ADDITIONAL CHARGES AND ALLEGATIONS

26. On or December 27, 1993, respondent provided investigator Mary Beth Kania a six page letter purportedly written by a Dan Kortman who was and is employed as an Implantable Sales Specialist for Medtronic, Inc.

27. Said letter purported to explain respondent's conduct in dealing with a patient by the name of Karen Schilling, who was listed as one of the complaining witnesses in Accusation 10-91-15215.

28. On June 26, 1995, Dr. Domininck Addario, M.D., submitted a report following his psychiatric examination of respondent on March 23, 1995, and April 29,1995. Among the documents received by Dr. Addario for his consideration in rendering his evaluation of respondent was the six-page letter purportedly written by Mr. Kortman and referred to in paragraphs 26 and 27, supra.

29. Subsequent to the evaluation performed by Dr. Addario complainant received a signed declaration from Mr.

Kortman indicating he had never written or caused to have written the letter submitted by respondent. Mr. Kortman indicated the signature appearing at the bottom of the letter was not his.

30. Respondent has knowingly submitted a false document directly reflecting on his ability to practice medicine. In so doing, he has violated sections 2234 (e) and 2261 of the Medical Practice Act.

PRAYER

WHEREFORE, complainant prays that the Board hold a hearing and:

1. Revoke respondent's certificate to practice medicine;

2. Take such other and further action as the Division deems appropriate to protect the public health, safety, and welfare.

DATED: Aug 17, 1995

Doug Laue
Acting Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

DANIEL E. LUNGREN, Attorney General
of the State of California
STEVEN H. ZEIGEN,
Deputy Attorney General, State Bar No. 60225
Department of Justice
110 West A Street, Suite 1100
Post Office Box 85266
San Diego, California 92186-5266
Telephone: (619) 645-2074

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PAUL KEVIN BARKAL, M.D. 4540 Park Newport Newport Beach, CA 92660 Physician's and Surgeon's Certificate No. A044292	NO. 10-91-15215 SECOND SUPPLEMENTAL ACCUSATION

Complainant Ron Joseph alleges as follows:

31. He is the Executive director of the Medical Board of California ("Board") and makes and files this Second Supplemental Accusation in his official capacity.

32. Complainant refers to the allegations contained in paragraphs 1 through 22 of the Accusation No. 10-91-15215 filed on or about April 28, 1995, filed by former Executive Director, Dixon Arnett, and paragraphs 23 through 30 of the First Supplemental Accusation, filed on or about August 17, 1995, by former Acting Executive Director, Doug Laue, and incorporates the same herein by reference as if fully set forth.

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33. This Amended Accusation is made in reference to the following sections of the California Business and Professions Code:

A. Section 2227 provides that the Board may revoke, suspend for a period of not more than one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 provides that unprofessional conduct includes, but is not limited to, the following:

1. Repeated negligent acts (subdivision (c));

2. The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon (subdivision (e)). [1]

ADDITIONAL CHARGES AND ALLEGATIONS

Patient E.G.

34. During September 1994, E.G. began receiving treatment from at the Alexian Brothers Medical Center in Elk Grove Village, Illinois. She had been referred by an orthopedic surgeon, K. S., M.D., for pain in her right rib cage area.

35. On October 3, 1994, Respondent performed a spinal infusion, at the Alexian Brothers facility, which caused the patient excruciating pain, and numbing from her chest to her toes. Respondent had told E.G. the procedure would take twenty

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1. Unprofessional conduct is that conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming a member in good standing of the medical profession, and which demonstrated an unfitness to practice medicine.

minutes. Because of her reaction, however, E.G. was hospitalized for 8 1/2 hours at the facility. Neither E.G. nor the hospital staff were able to reach respondent during E.G.'s stay at the facility, nor had respondent left any written orders for the staff.

36. E.G. continued to have severe headaches on October 4, 5, 6, 1994, during which time she was unable to reach respondent. On October 6th, E.G. experienced a reaction to the antibiotic keflex she had been given, and was unable to reach respondent for 14 hours, until he prescribed compazine.

37. Between October 7-10, 1994, E.G. continued to experience head and rib cage pain. Respondent saw the patient on October 10th at which time he ordered the nurse to bolus E.G. three times between October 10 and October 13, 1994.

38. On October 16, 1994, E.G. became numb again from her chest to her toes. The home care nurse caring for her had paged respondent to no avail. Five days passed until respondent returned a page to E.G. on October 18, 1994.

39. The pain from the infusion continued. E.G. was again unable to make contact with respondent, and again went to the emergency room at Alexian Brothers, where she was told the catheter could not be removed because respondent had tunneled it under the skin. E.G. contacted respondent, who said he could not remove the catheter for four days. When E.G. asked the Director of Alexian Brothers, Dr. M., for a referral she was told respondent had left no one to cover his patients while he was out of state.

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40. Respondent has subjected his license to disciplinary action under code sections 2220, 2227, and 2234 on the grounds of unprofessional conduct. Said unprofessional conduct included, but was not limited to:

A. Paragraphs 34-39 are incorporated by reference and realleged as if fully set forth herein.

B. Respondent failed to provide back-up for his patient during the time he was out of the state.

C. Respondent failed to respond in a timely fashion to the repeated attempts of his patient to contact him.

Patient K.K.

41. Patient K.K. was being treated by orthopedist, K.S., M.D. who referred her to respondent for treatment of pain caused by an automobile accident.

42. On or about April 7, 1995, respondent performed a placement of a lumbar epidural catheter, injection of lumbar epidural steroids, and intravenous infusion therapy on K.K. at the Alexian Brothers Medical Center. Respondent left the facility immediately after the surgery. K.K. was unable to walk and was in pain, although respondent cleared her with the staff to go home when he finally returned the calls from the hospital at 9:00 p.m. that evening.

43. Prior to the surgery, respondent had told K.K. he could be reached by 24 hour answering service. After the surgery, K.K. attempted to reach respondent on several occasions. He never responded.

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44. K.K. scheduled with respondent to remove the catheter on May 12, 1995. When she called the Alexian Brothers Medical Center to confirm the date K.K. was told respondent was in California. From May 12 through May 14 K.K. changed her own pump, and bolused herself.

45. K.K. went back to Alexian Brothers to have the catheter removed, but no one there would remove the catheter in the absence of orders from respondent. Because respondent failed to respond to the contacts from K.K., she was forced to have a Dr. Terry D., M.D, from the Northern Illinois Medical Center remove the catheter on May 15, 1995.

46. Respondent has subjected his license to disciplinary action under code sections 2220, 2227, and 2234 on the grounds of unprofessional conduct. Said unprofessional conduct included, but was not limited to:

A. Paragraphs 41-45 are incorporated by reference and realleged as if fully set forth herein.

B. Respondent failed to provide back-up for his patient during the time he was out of the state.

C. Respondent failed to respond in a timely fashion to the repeated attempts of his patient to contact him.

D. Respondent abandoned his patient, K.K.

Patient J.T-G.

47. In February 1995, patient J.T-G. made an appointment with Dr. M., of the Alexian Brothers Medical Center for treatment of her chronic back pain. Respondent returned J.T-G.'s call and said he was the head of the Alexian Brothers

Pain Management Department and she had to see him first. Respondent cancelled the appointment J.T-G. made with Dr. M., and made an appointment with respondent.

48. As a result of his examination of her, respondent performed three lumbar epidurals on J.T-G., the first of which was on April 6, 1995.

49. On April 24, 1995, respondent performed the second, which caused J.T-G. to become paralyzed and caused her to be admitted to the hospital for five hours until her paralysis left. During that time, nurses were unable to contact respondent for the placing of a catheter.

50. Patient J.T-G. stopped her therapy with respondent in September 1995, but kept taking her amitriptyline for pain. When she tried reaching respondent for a prescription refill in February 1996, she was told by Alexian Brothers respondent was no longer working there. She ultimately talked with Dr. M., who informed her, inter alia, respondent was never the head of pain management at Alexian Brothers.

51. Respondent has subjected his license to disciplinary action under code sections 2220, 2227, and 2234 on the grounds of unprofessional conduct. Said unprofessional conduct included, but was not limited to:

A. Paragraphs 47-49 are incorporated by reference and realleged as if fully set forth herein.

B. Respondent failed to respond in a timely fashion to the calls from the hospital following the second epidural during which J.T-G. was paralyzed for five hours.

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C. Respondent misrepresented his position at Alexian Brothers at the time he changed J.T-G.'s scheduled appointment with Dr. M, within the meaning of sections 2234, subdivision (e), and 2271. He never was the "head" of pain management at Alexian Brothers Medical Center.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 04492, heretofore issued to respondent Paul Kevin Barkal, M.D.;

2. Directing respondent to pay the Division the actual and reasonable costs of the investigation and enforcement of this case; and directing respondent, if placed on probation, to pay the costs of the probation monitoring;

3. Taking such other and further action as the Division deems necessary and proper.

DATED: 12-3-96

Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

SHZ:pll